BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

PIERRE KAMGUIA, M.D., RESPONDENT

FILE No. 02-11-672

****

DISMISSAL ORDER

****

Date: August 28, 2015.

1. Respondent was issued Iowa medical license no. 34474 on February 8, 2002.

2. Respondent's Iowa medical license has been inactive due to non-renewal since January 1, 2004.

3. **Practice Setting:** Respondent is an Iowa-licensed physician who formerly practiced ophthalmologic surgery in Martinsville, Virginia.

4. **Virginia Disciplinary Action:** On or about October 25, 2011, the Virginia Board of Medicine (Virginia Board) disciplined Respondent for failing to meet the standard of care in his treatment of at least seven patients who suffered complications while undergoing phacoemulsification cataract extraction and intraocular lens insertion between September 11, 2008 and July 23, 2009, in Martinsville, Virginia. The Virginia Board also concluded that Respondent failed to appropriately respond to calls from the hospital's emergency department for an apparent emergent situation while he was on call on or about

December 7, 2009. The Virginia Board noted that Respondent last performed surgery in November 2009 and that he was not practicing medicine at the time of the order. The Virginia Board placed Respondent on indefinite probation and ordered him to complete additional continuing medical education in the subjects of professionalism in the practice of medicine and cataract surgery. Prior to returning to the practice of medicine, Respondent was required to submit a practice plan describing his: practice location; hours, healthcare services offered, staffing; hospital privileges for medical personnel; and the procedures to be performed and the type of treatment/services to be provided. Should the plan include ophthalmologic surgery, Respondent must submit the name and CV of a proctor who will supervise him for a minimum of twenty-five (25) cataract surgical procedures. See Attachment A.

5. **Iowa Disciplinary Charges:** On October 25, 2013, the Iowa Board filed formal disciplinary charges against Respondent charging him with being disciplined by the licensing authority of another state in violation of the laws and rules governing the practice of medicine in Iowa. See Attachment B.

8. **Relinquishment of Iowa Medical License:** Effective July 1, 2015, pursuant to Iowa Code section 148.8A, Respondent's Iowa medical license was relinquished because he failed to apply for renewal or reinstatement of the license within five (5) years after its expiration. See Iowa Code section 148.8A. Respondent's Iowa medical license may not be reinstated, reissued, or restored once it has been relinquished. Therefore, Respondent no longer holds an Iowa medical license.

THEREFORE IT IS ORDERED: that the Board hereby **DISMISSES** the Statement of Charges currently pending against Respondent in this matter. However, should Respondent apply for a new Iowa medical license in the future, the Board will reopen this matter and take appropriate action necessary to protect the public.

This order becomes effective on August 28, 2015.

Hamed H. Tewfik, M.D., Chairman
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

Attachment A

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: PIERRE KAMGUIA, M.D.
License No.: 0101-243591

ORDER

In accordance with the provisions of Sections 54.1-105, 54.1-110, 2.2-4020 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was convened before the Virginia Board of Medicine ("Board"), on October 7, 2011, in Henrico, Virginia, to receive and act upon evidence that Pierre Kamguia, M.D., may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia, as set forth in the Board's Notice of Hearing and Statement of Particulars dated August 19, 2011.

Pursuant to Sections 2.2-4024.F and 54.1-2400(11) of the Code, the hearing was held before a panel of the Board with a member of the Board presiding. Amy Marschean, Senior Assistant Attorney General, was present as legal counsel for the Board. The proceedings were recorded by a certified court reporter. The case was prosecuted by James Schliessmann, Assistant Attorney General, assisted by Julia K. Bennett, Adjudication Specialist. Dr. Kamguia appeared at the formal administrative hearing and was not represented by counsel.

FINDINGS OF FACT

Now, having properly considered the evidence and testimony presented, the Board makes the following findings of fact by clear and convincing evidence:

1. Pierre Kamguia, M.D., was issued license number 0101-243591 by the Board to practice medicine and surgery in the Commonwealth of Virginia on May 2, 2008. Said license is currently active and will expire on March 31, 2012, unless renewed or acted upon.

2. Dr. Kamguia failed to meet the standard of care in his treatment of the following patients and practiced in a manner posing a danger to their health and welfare, in that:

a. On or about September 11, 2008, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the left eye of Patient A. During cortical removal, vitreous was noted at the limbal incision. Dr. Kamguia failed to remove all cortical material, leaving approximately one-third of the cortex in the eye. Further, according to Dr. Kamguia's operative report, he placed a plate haptic style intraocular lens in the ciliary sulcus, which is a lens not indicated for placement in the ciliary sulcus.

b. On or about September 25, 2008, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the left eye of Patient B. During insertion of the intraocular lens, Dr. Kamguia ruptured the posterior capsule. He failed to record the status of the vitreous body following the rupture. Further, Dr. Kamguia placed a plate haptic style intraocular lens in the ciliary sulcus, which is a lens not indicated for placement in the ciliary sulcus.

c. On or about October 9, 2008, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the right eye of Patient C. During phacoemulsification, Dr. Kamguia ruptured the posterior capsule and lost a lens

fragment into the vitreous cavity.

d. On or about October 9, 2008, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the right eye of Patient D. After Dr. Kamguia inserted the intraocular lens into the capsular bag, he noted that the lens was truncated at the trailing haptic plate junction. Despite the fact that the lens was defective and he was concerned about its stability, Dr. Kamguia failed to replace the lens and instead left it in the eye.

e. On or about November 13, 2008, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the right eye of Patient E. After entering the anterior chamber but prior to initiating capsulorrhexis, the operating microscope malfunctioned, leaving Dr. Kamguia without fine focus capability. Despite this, Dr. Kamguia failed to abort the procedure and proceeded with lens extraction, during which he ruptured the posterior capsule.

f. On or about April 9, 2009, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the left eye of Patient F, during which he ruptured the posterior capsule, necessitating an anterior vitrectomy.

g. On or about July 23, 2009, Dr. Kamguia performed phacoemulsification cataract extraction and intraocular lens insertion on the right eye of Patient G, during which he ruptured the posterior capsule, necessitating an anterior vitrectomy.

h. On or about December 7, 2009, when on call for the hospital's emergency department, Dr. Kamguia failed to respond to multiple messages regarding a patient with bleeding from the eye. Dr. Kamguia later admitted to Faye Sedwick,

Quality Assessment Services Director, Memorial Hospital of Martinsville and Henry County, that he failed to respond to the hospital's emergency department's call.

i. The Board's expert, Alan J. Fink, M.D., opined, "there is evidence of deficient technical skills as well as a lack of appropriate clinical judgment which places patients at increased risk.... the level of care demonstrated by Dr. Kamguia falls below the acceptable standard." Dr. Fink testified that the generally accepted rate for the major complication of posterior capsule rupture during cataract surgery is 1-2% for experienced surgeons. Dr. Kamguia was above the generally accepted standard. Dr. Fink testified that placing the plate haptic style intraocular lens in the ciliary sulcus for cataract surgery is not a generally accepted practice in the ophthalmologic community. Dr. Fink testified that, to a reasonable degree of medical and ophthalmologic certainty, Dr. Kamguia failed to meet the standard of care. He further testified that complications can occur when the plate haptic lens is placed in the ciliary sulcus.

j. Regarding Patients A-G, Dr. Kamguia stated, "Whatever we subjectively think of the handling of the complications, two facts remain unchallenged and verifiable: it resulted in good outcomes in all cases, and there have been no patient complaints to date." Dr. Kamguia stated his complications were due to a new environment, new staff and new equipment, and his hiatus from surgical practice.

3. The Board's review of the medical records provided in evidence indicated Dr. Kamguia failed to record (i) the preoperative visual acuity in the hospital records of

Patients A, B, C and D; (ii) the preoperative visual acuity in the hospital History and Physical Examination of Patient E; and (iii) objective findings of his preoperative eye examinations, other than the presence of cataracts, and failed to record any potential increased risk factors for cataract surgery in the hospital records of Patients A - G. Further, Dr. Kamguia dictated late operative reports for Patients A, C, D and E. Dr. Kamguia explained that the records submitted to the Board only reflected his hospital records and were not the complete patient records. Dr. Kamguia claimed that this information was recorded in his office records; however, Dr. Kamguia failed to provide the Board this information to review.

4. Ms. Sedwick testified that because of concerns about Dr. Kamguia's complication rate, the hospital peer review committee commenced an external peer review that was conducted by The Greeley Company, which led to the hospital's restriction of his performance of cataract surgeries. In response to the review, the hospital offered Dr. Kamguia a Corrective Action Plan, which he rejected.

5. Garth Stevens, Jr., M.D., testified as an expert for Dr. Kamguia. He testified that initially Dr. Kamguia had a high complication rate, but stated over time it did improve. In his review of the records, his opinion was that Dr. Kamguia's surgical performance "is, although not ideal, within the range of reasonable medical practice for the state of Virginia." Dr. Stevens opined that the complications that Dr. Kamguia had were not unusual and are known complications for such surgical procedures.

6. Dr. Kamguia stated he last performed surgery in November 2009 and that he is not currently practicing medicine.

7. When questioned about his care of Patients A-G and their surgical complications, Dr. Kamguia was evasive, avoided personal responsibility, and generally blamed others.

8. Pastor John W. Tinsley appeared as a character witness on behalf of Dr. Kamguia. He testified that he has known Dr. Kamguia for two years and found him to be a sincere man and concerned about the care of others. He says Dr. Kamguia has great integrity.

CONCLUSIONS OF LAW

The Board concludes that Finding of Fact No. 2 violates Sections 54.1-2915.A(3), (13) and (16) of the Code.

ORDER

WHEREFORE, it is hereby ORDERED that the license of Pierre Kamguia, M.D., is placed on INDEFINITE PROBATION, subject to the following terms and conditions:

1. Within one year from entry of this Order, Dr. Kamguia shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed at least fifteen (15) hours of continuing medical education ("CME") in the subject of professionalism in the practice of medicine. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

2. Within one year from entry of this Order, Dr. Kamguia shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed at least ten (10) hours of CME in the subject of cataract surgery. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

3. Prior to returning to practice, Dr. Kamguia shall present a practice plan (i.e., practice location, hours, health care services offered, staffing (both medical and non-medical personnel), hospital privileges for medical personnel, and description of procedures to be performed and type of treatment/services to be provided) to the Board for approval. Should this plan include ophthalmologic surgery, Dr. Kamguia will provide the Board with the name and curriculum vitae of a proctor who will supervise him for a minimum of twenty-five (25) cataract surgical procedures. The proctor shall be a Board-certified Virginia licensed ophthalmologist and approved by the Board. Said proctor shall provide detailed reports to the Board concerning Dr. Kamguia's surgical skills and judgment on a monthly basis.

4. Upon compliance with the above terms, the Board authorizes the Executive Director to terminate the indefinite probation and foregoing terms or to refer the matter to a Special Conference Committee for its review and determination.

Dr. Kamguia shall maintain a course of conduct in his practice of medicine and surgery commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Violation of this Order may constitute grounds for the suspension or revocation of Dr. Kamguia's license. In the event Dr. Kamguia violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Dr. Kamguia has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with William L. Harp, M.D., Executive Director, Board of Medicine, at 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 10/25/11

Attachment B

BEFORE THE IOWA BOARD OF MEDICINE

****

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

PIERRE KAMGUIA, M.D., RESPONDENT

FILE No. 02-11-672

****

STATEMENT OF CHARGES

****

COMES NOW the Iowa Board of Medicine (Board) on October 25, 2013, and files this Statement of Charges pursuant to Iowa Code Section 17A.12(2). Respondent was issued Iowa medical license no. 34474 on February 8, 2002. Respondent's Iowa medical license went inactive due to nonrenewal on January 1, 2004.

A. TIME, PLACE AND NATURE OF HEARING

1. Hearing. A disciplinary contested case hearing shall be held on January 9, 2014, before the Iowa Board of Medicine. The hearing shall begin at 10:30 a.m. and shall be located in the conference room at the Iowa Board of Medicine office at 400 SW 8th Street, Suite C, Des Moines, Iowa.

2. Answer. Within twenty (20) days of the date you are served this Notice of Hearing you are required by 653 Iowa Administrative Code 25.10 to file an Answer. In that Answer, you should also state whether you will require a continuance of the date and time of the hearing.

3. Presiding Officer. The Board shall serve as presiding officer, but the Board may request an Administrative Law Judge make initial rulings on prehearing matters, and be present to assist and advise the board at hearing.

4. Prehearing Conference. A prehearing conference will be held by telephone on December 4, 2013, at 9:30 a.m., before an Administrative Law Judge from the Iowa Department of Inspections and Appeals (ALJ). Please contact Kent M. Nebel, J.D., Legal Director, Iowa Board of Medicine, at 515-281-7088 with the telephone number at which you or your legal counsel can be reached. Board rules on prehearing conferences may be found at 653 Iowa Administrative Code 25.15.

5. Hearing Procedures. The procedural rules governing the conduct of the hearing are found at 653 Iowa Administrative Code Chapter 25. At hearing, you will be allowed the opportunity to respond to the charges against you, to produce evidence on your behalf, cross-examine witnesses, and examine any documents introduced at hearing. You may appear personally or be represented by counsel at your own expense. If you need to request an alternative time or date for hearing, you must review the requirements in 653 Iowa Administrative Code 25.16. The hearing may be open to the public or closed to the public at the discretion of the Respondent.

6. Prosecution. The office of the Attorney General is responsible for representing the public interest (the State) in this proceeding. Pleadings shall be filed with the Board and copies should be provided to counsel for the State at the following address: Julie Bussanmas, Assistant Attorney General, Iowa Attorney General's Office, 2nd Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7. Communications. You may not contact board members by phone, letter, facsimile, e-mail, or in person about this Notice of Hearing. Board members may only receive information about the case when all parties have notice and an opportunity to participate, such as at the hearing or in pleadings you file with the Board office and serve upon all parties in the case. You may contact Kent M. Nebel, J.D., Legal Director, at 515-281-7088 or to Assistant Attorney General Julie Bussanmas at 515-281-5637.

B. LEGAL AUTHORITY AND JURISDICTION

8. Jurisdiction. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 17A, 147, 148, and 272C.

9. Legal Authority: If any of the allegations against you are founded, the Board has authority to take disciplinary action against you under Iowa Code Chapters 17A, 147, 148, and 272C (2005) and 653 Iowa Administrative Code Chapter 25.25.

10. Default. If you fail to appear at the hearing, the Board may enter a default decision or proceed with the hearing and render a decision in your absence, in accordance with Iowa Code Section 17A.12(3) and 653 Iowa Administrative Code 25.20.

C. SECTIONS OF STATUTES AND RULES INVOLVED

COUNT I

11. **Discipline by Another Licensing Authority:** Respondent is charged pursuant to Iowa Code section 148.6(2)(d) and 653 IAC 23.1(1) with having a license to practice medicine and surgery or osteopathic medicine and surgery revoked or suspended, or having other disciplinary action taken by a licensing authority of another state, territory, or country. A certified copy of the order of disciplinary action is prima facie evidence.

STATEMENT OF THE MATTERS ASSERTED

12. Respondent is an Iowa-licensed physician who formerly practiced ophthalmologic surgery in Martinsville, Virginia.

13. On or about October 25, 2011, the Virginia Board of Medicine (Virginia Board) disciplined Respondent for failing to meet the standard of care in his treatment of at least seven patients who suffered complications while undergoing phacoemulsification cataract extraction and intraocular lens insertion between September 11, 2008 and July 23, 2009, in Martinsville, Virginia. The Virginia Board also concluded that Respondent failed to appropriately respond to calls from the hospital's emergency department for an apparent emergent situation while he was on call on or about December 7, 2009. The Virginia Board noted that Respondent last performed surgery in November 2009 and that he was not practicing medicine at the time of the order. The Virginia Board placed Respondent on indefinite probation and ordered him to complete additional continuing medical education in the subjects of professionalism in the practice of medicine and cataract surgery. Prior to

returning to the practice of medicine, Respondent was required to submit a practice plan describing his: practice location; hours, healthcare services offered, staffing; hospital privileges for medical personnel; and the procedures to be performed and the type of treatment/services to be provided. Should the plan include ophthalmologic surgery, Respondent must submit the name and CV of a proctor who will supervise him for a minimum of twenty-five (25) cataract surgical procedures. See Attachment A.

E. SETTLEMENT

14. Settlement. This matter may be resolved by settlement agreement. The procedural rules governing the Board's settlement process are found at 653 Iowa Administrative Code 12.25. If you are interested in pursuing settlement of this matter, please contact Kent M. Nebel, J.D., Legal Director at 515-281-7088.

F. PROBABLE CAUSE FINDING

15. On October 25, 2013, the Iowa Board of Medicine found probable cause to file this Statement of Charges.

Greg Hoversten DO

Gregory B. Hoversten, D.O., Chairman
Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, Iowa 50309-4686

BEFORE THE IOWA BOARD OF MEDICINE

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IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

PIERRE KAMGUIA, M.D., RESPONDENT

FILE No. 02-11-672

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Iowa Board of Medicine
400 SW 8th Street, Suite C
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Attachment A

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: PIERRE KAMGUIA, M.D.
License No.: 0101-243591

ORDER

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FINDINGS OF FACT

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2. Dr. Kamguia failed to meet the standard of care in his treatment of the following patients and practiced in a manner posing a danger to their health and welfare, in that:

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j. Regarding Patients A-G, Dr. Kamguia stated, "Whatever we subjectively think of the handling of the complications, two facts remain unchallenged and verifiable: it resulted in good outcomes in all cases, and there have been no patient complaints to date." Dr. Kamguia stated his complications were due to a new environment, new staff and new equipment, and his hiatus from surgical practice.

3. The Board's review of the medical records provided in evidence indicated Dr. Kamguia failed to record (i) the preoperative visual acuity in the hospital records of

Patients A, B, C and D; (ii) the preoperative visual acuity in the hospital History and Physical Examination of Patient E; and (iii) objective findings of his preoperative eye examinations, other than the presence of cataracts, and failed to record any potential increased risk factors for cataract surgery in the hospital records of Patients A - G. Further, Dr. Kamguia dictated late operative reports for Patients A, C, D and E. Dr. Kamguia explained that the records submitted to the Board only reflected his hospital records and were not the complete patient records. Dr. Kamguia claimed that this information was recorded in his office records; however, Dr. Kamguia failed to provide the Board this information to review.

4. Ms. Sedwick testified that because of concerns about Dr. Kamguia's complication rate, the hospital peer review committee commenced an external peer review that was conducted by The Greeley Company, which led to the hospital's restriction of his performance of cataract surgeries. In response to the review, the hospital offered Dr. Kamguia a Corrective Action Plan, which he rejected.

5. Garth Stevens, Jr., M.D., testified as an expert for Dr. Kamguia. He testified that initially Dr. Kamguia had a high complication rate, but stated over time it did improve. In his review of the records, his opinion was that Dr. Kamguia's surgical performance "is, although not ideal, within the range of reasonable medical practice for the state of Virginia." Dr. Stevens opined that the complications that Dr. Kamguia had were not unusual and are known complications for such surgical procedures.

6. Dr. Kamguia stated he last performed surgery in November 2009 and that he is not currently practicing medicine.

7. When questioned about his care of Patients A-G and their surgical complications, Dr. Kamguia was evasive, avoided personal responsibility, and generally blamed others.

8. Pastor John W. Tinsley appeared as a character witness on behalf of Dr. Kamguia. He testified that he has known Dr. Kamguia for two years and found him to be a sincere man and concerned about the care of others. He says Dr. Kamguia has great integrity.

CONCLUSIONS OF LAW

The Board concludes that Finding of Fact No. 2 violates Sections 54.1-2915.A(3), (13) and (16) of the Code.

ORDER

WHEREFORE, it is hereby ORDERED that the license of Pierre Kamguia, M.D., is placed on INDEFINITE PROBATION, subject to the following terms and conditions:

1. Within one year from entry of this Order, Dr. Kamguia shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed at least fifteen (15) hours of continuing medical education ("CME") in the subject of professionalism in the practice of medicine. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

2. Within one year from entry of this Order, Dr. Kamguia shall submit a certificate or other evidence satisfactory to the Board verifying that he has completed at least ten (10) hours of CME in the subject of cataract surgery. Such CME shall be approved in advance of registration by the Executive Director of the Board, and shall be completed through face-to-face, interactive sessions (i.e., no home study, journal or Internet courses). Any CME hours obtained in compliance with this term shall not be used toward compliance with the Board's continuing education requirements for license renewal.

3. Prior to returning to practice, Dr. Kamguia shall present a practice plan (i.e., practice location, hours, health care services offered, staffing (both medical and non-medical personnel), hospital privileges for medical personnel, and description of procedures to be performed and type of treatment/services to be provided) to the Board for approval. Should this plan include ophthalmologic surgery, Dr. Kamguia will provide the Board with the name and curriculum vitae of a proctor who will supervise him for a minimum of twenty-five (25) cataract surgical procedures. The proctor shall be a Board-certified Virginia licensed ophthalmologist and approved by the Board. Said proctor shall provide detailed reports to the Board concerning Dr. Kamguia's surgical skills and judgment on a monthly basis.

4. Upon compliance with the above terms, the Board authorizes the Executive Director to terminate the indefinite probation and foregoing terms or to refer the matter to a Special Conference Committee for its review and determination.

Dr. Kamguia shall maintain a course of conduct in his practice of medicine and surgery commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Violation of this Order may constitute grounds for the suspension or revocation of Dr. Kamguia's license. In the event Dr. Kamguia violates this Order, an administrative proceeding may be convened to determine whether such action is warranted.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Dr. Kamguia has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with William L. Harp, M.D., Executive Director, Board of Medicine, at 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 10/25/11